

Prevention and Control of Infectious Diseases: Integrating Ethical and Human Rights Principles into Public Health Laws

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Citation: Singh, S, C. (2025). Prevention and Control of Infectious Diseases: Integrating Ethical and Human Rights Principles into Public Health Laws. *Epidemiol Public Health OA*, 1(1), 01-21.

Abstract

All countries around the world continued to fight the outbreak of the Coronavirus (COVID-19) and dealt with the disease. The question arises how this public health crisis affects individual and human rights. It is essential that we should not ignore human rights during this crisis, even our primary focus may be to fight the outbreak and cure for the disease. The epidemic and the legal responses to it have serious consequences on people's lives. In response to the epidemics, public health laws in USA, UK, Canada, Australia and many other countries allow health departments and public health officials to impose a number of measures that affect people's lives and their human rights. These measures include detaining people to be screened, collecting their health information, and putting them in isolation and quarantine against their will. People who do not comply with orders by public health officials, or obstruct their work can face criminal charges. While these types of measures are essential during such emergencies, it is worth noting that they do interfere with basic human rights, especially the right to liberty. In the recent past India has imposed draconian restrictions throughout the country, subjecting the whole population to a legally enforceable quarantine and thus violating fundamental freedoms.

Keywords: Infectious Disease, Coronavirus (Covid-19), HIV/AIDS, Public Health Law, Isolation and Quarantine, World Health Organization, Criminalization of Transmission, International Human Rights Law

Introduction

Law can contribute to the prevention of infectious diseases by improving access to vaccinations and contraceptives, and by facilitating screening, counselling and education of those at risk of infection. Law also has a reactive role: supporting access to treatment and authorising public health authorities to limit contact with infectious individuals and to exercise emergency powers in response to disease outbreaks. Where public health laws authorise interferences with freedom of movement, the right to control one's health and body, privacy, and property rights, they should balance these private rights with the public health interest in an ethical and transparent way. Public health powers should be based on

the principles of public health necessity, reasonable and effective means, proportionality, distributive justice, and transparency. Immunization is a successful and cost-effective public health strategy that saves millions of lives each year. Government can support vaccination coverage by ensuring that vaccination is free or affordable, by ensuring that all persons are vaccinated (with limited exceptions for medical or religious reasons), and that vaccinations are documented.

Early treatment has been important public health benefits; for example, people receiving treatment for tuberculosis and HIV infection are less likely to transmit the infection to others. Health laws can improve the success of voluntary screening programmes by including counselling requirements, ensuring the confidentiality of test results, and protecting individuals diagnosed with particular diseases from discrimination. Public health laws should protect the confidentiality of a person's positive status, authorising disclosure to third parties only in limited circumstances where a third party is at significant risk of transmission and where other statutory preconditions are met.

Government should carefully consider the appropriate role of criminal law when making or amending laws to prevent the transmission of infectious and communicable diseases. For example, criminal penalties for transmission of infectious diseases may create disincentives to individuals to come forward for testing and treatment, or may provide the pretext for harassment and violence against vulnerable groups. Encouraging personal responsibility and self-protection is critical, especially in countries where rates of CORONA infections are high. Public health laws should authorise compulsory treatment only in circumstances where an individual is unable or unwilling to consent to treatment, and where their behaviour creates a significant risk of transmission of a serious disease. Compulsory treatment orders should restrict individual liberty only to the extent necessary to most effectively reduce risks to public health.

In an unprecedented step, the law also creates new criminal offences for people who do not comply with detention orders, abscond from a place of isolation, supply false or misleading information or who obstruct public health officials conducting their duties. The police are now empowered to use reasonable force to enforce these rules in the interests of public safety. Quarantines and travel bans are often the first response against new infectious diseases. However, these old tools are usually of limited utility for highly transmissible diseases, and if imposed with too heavy a hand, or in too haphazard a manner, they can be counterproductive, particularly with a virus such as COVID-19, they cannot provide a sufficient response.

Legal framework for responding to public health emergencies

Legal measures play a very important role in controlling infectious diseases. With proper legal framework, infectious diseases can be contained at a very early stage by creating awareness of screening, counselling and education of the public. This limits the contact of suspects of infectious disease with the general public and also takes swift coercive measures if needed. For mitigating the spread of infectious diseases both Union and State Governments are constitutionally entitled to legislate.

The earliest legislation that deals with in public health matters is the Epidemic Diseases Act, 1897.¹ This legislation empowers the Central Government and the State Governments

to take the warranted measures for controlling the spread of the epidemic. Both the Governments if they believe that there is a probable outbreak, has the power to take all the necessary measures like detaining an individual, the affected ones, controlling the movement of visitors at seaport, airport, railway stations, and state borders, etc. The 1897 Epidemic Act gives flexibility to States in making Regulations under the act to devise their own strategies and responses in a given situation that would be peculiar to their conditions. This act has only four sections in total and is probably one of the shortest acts in India. Some powers have been given to the State Governments under section 2 of this act while some powers have been given to the Central Government under section 2 (A) to control an outbreak of dangerous epidemic disease. Section 3 deals with penalty while section 4 deals with the protection to persons acting under the act in the prevention and control and treatment. The act lays down punishment as per section 188 of the Indian Penal Code, 1860.

The Epidemic Diseases Act, 1897 ("EDA") was first enacted to tackle the bubonic plague in the then Bombay State. However, the act was not actively invoked further, except locally. The act was previously enforced in some states for dealing with outbreaks of diseases such as swine flu, dengue, and cholera. Examples of the previous implementations include combating: swine flu in Pune in 2009, dengue and malaria in Chandigarh in 2015, cholera in Gujarat in 2018, and Corona in 2020 across India. Recently, the act was amended in the context of COVID-19 via the ordinance by the Epidemic Diseases (Amendment) Ordinance 2020 and provisions to punish those attacking doctors or health workers were added.² The ordinance allows for up to seven years of jail for attacking doctors or health workers (including ASHA workers). The offence is made cognizable and non-bailable.

In addition, the old Indian Penal Code, 1860 ("IPC") and Criminal Procedure Code, 1973 ("CrPC") as well as the new Bharatiya Nyaya Sanhita, 2023 and the Bharatiya Nagrik Suraksha Sanhita, 2023 play a pivotal role in the proper implementation of EDA. Both the old and the new codes fulfil the aspect of sanction if any provision of or any order or regulation emanating from EDA is violated. Various provisions of IPC, CrPC and the new penal codes are in line with achieving the objectives of public health laws. For instance, section 269 of IPC (section 271 of new Code) deals with the negligent act of spreading infectious disease dangerous to life. Section 270, IPC (section 272 of new Code) deals in a malignant act of spreading infectious disease dangerous to life, and section 271 of IPC (section 273 of new Code) deals in disobedience of the quarantine rule. Section 144 of CrPC (section 163 of new Code) talks about prohibiting public gathering for enforcing lockdown. Further, the Epidemic Diseases Act makes a direct mention of section 188 of the IPC which talks about the disobedience of order duly promulgated by public servant. This portrays the dependence of EDA to secure the obedience of its orders and regulations made during the time of emergency on the old and new penal laws. There have been several instances till now during this pandemic, where people have been booked under section 269 and section 270 for flouting the quarantine and lockdown rules. History of such instances can be dated back to the year 1883, in which the Madras High Court held a person guilty for travelling by train despite suffering from cholera under section 269.³ A similar case of *Nadir Mal* came up, in the year 1902, wherein the accused was held guilty

under section 269 who negligently travelling by train after living in a plague-stricken house and had been in contact with a plague patient.⁴

India is still using the 150-year-old colonial legislation (recently replaced by the Bharatiya Nyaya Sanhita, 2023) to combat infectious diseases which has been used to curb the spread of fatal diseases, like Plague, Ebola, and Severe Acute Respiratory Syndrome (SARS).⁵ The old IPC is now replaced by the Bharatiya Nyaya Sanhita, 2023 as the old legislation has various shortcomings. Still, the problem is that the health being a state subject, the best Union Government can do is to advise and coordinate with the States. This shortcoming remains because of constitutional provision under which health comes under the State List. Also, under section 2 of the EDA, the Centre is empowered to “inspect any ship or vessel leaving or arriving at any port” excluding modes of transport by air. Due to the lack of a comprehensive legal framework, the government is forced to uplift archaic law to tackle such infectious disease of pandemic nature, which does not even provide the definition of the words, like “pandemic” or “epidemic.”

As the word ‘epidemic’ is not defined by the Executive order or Legislative framework, the Court must look to its ordinary meaning.⁶ When the word used in a statute is not defined in the statute, dictionary definitions serve as useful guidelines in determining the word’s ‘ordinary’ and ‘commonly understood’ meaning. Thus, an “epidemic” is defined as “an outbreak of disease that spreads quickly and affects many individuals at the same time.”⁷ Epidemic is also defined as “affecting or tending to affect a disproportionately large number of individuals within a population, community or region at the same time.”⁸

Also, there is no explicit reference about the ethical aspects of human rights principles during a response to a mass outbreak of an infectious disease. This act lacks a provision which empowers the Centre to step in and deal with biological emergencies. The need of the hour is to have a law which takes care of prevailing and anticipated public health needs, including scenarios such as COVID-19 with international spread. India, despite having a plethora of futile laws, primarily uses IPC sections 269 and 270 to control the negligent and malignant transmission of diseases. Despite endeavouring several initiatives to enact an effective law, India still awaits a dynamic law. The legislators can take help from the National Disaster Management Act, 2005 as it clearly defines all necessary terminology and explicit description of all the implementing measures to be exercised in the event of an emergency.

Public health laws and the limits of state powers

Public health laws have authorised public health officials to make orders for the isolation of an infected individuals, and the quarantine of those who have been exposed to a serious contagious disease. As with treatment orders, however these restrictions on autonomy should only be used as a last resort and should be minimally restrictive. For example, an infectious individual who does not require medical attention may be effectively quarantined within his or her home, rather than being confined in a hospital or other facility used as detention centre. Laws authorising mandatory confinement must also ensure that basic needs are met, including adequate shelter, food, water, and sanitation. They should also provide for appropriate treatment and health care and respect the cultural or religious expectations of quarantined or isolated individuals to the greatest

possible extent. National laws should also include procedural safeguards, by giving individuals who are the subject of a quarantine or isolation order the right to seek review by a court within a reasonable time.

Isolation limits the freedom of movement or action of a person or animal who is infected with (or is reasonably suspected of being infected with) a communicable disease or condition. Quarantine limits the freedom of movement or action of a person or animal who has been exposed (or is reasonably suspected of having been exposed) to a communicable disease or condition. Quarantine refers to the separation of those exposed individuals who are not yet symptomatic for a period of time (usually the known incubation period of the suspected pathogen) to determine whether they will develop symptoms. Basically, quarantine achieves two goals. First, it stops the chain of transmission because it is less possible to infect others if one is not in social circulation. Second, it allows the individuals under surveillance to be identified and directed toward appropriate care if they become symptomatic. This is more important in diseases where there is pre-symptomatic shedding of virus.⁹ Isolation, on the other hand, is keeping those who have symptoms from circulation in general populations.¹⁰ It should be noted that, despite controversies over quarantine, there is no clear or agreed-upon sense of what constitutes an effective quarantine.¹¹

Justification of quarantine and quarantine laws stems from a general moral obligation to prevent harm to (infection of) others if this can be done.¹² Most democracies have public health laws that do permit quarantine. Even though quarantine is a curtailment of civil liberties, it can be broadly justified if several criteria can be met. Ross Upshur¹³ identified four principles that must be met in order for public health to contemplate an autonomy-limiting strategy. First, the harm principle must be met. In other words, there should be clear and measurable harm to others should a disease or exposure goes unchecked. Secondly, the proportionality, or least-restrictive means, principle should be observed. This holds that public health authorities should use the least-restrictive measures proportional to the goal of achieving disease control. Thirdly, reciprocity must be upheld. If society asks individuals to curtail their liberties for the good of others, society has a reciprocal obligation to assist them in the discharge of their obligations. That means providing individuals with adequate food and shelter and psychological support, accommodating them in their workplaces, and not discriminating against them. Finally, there is the transparency principle. This holds that public health authorities have an obligation to communicate clearly the justification for their actions and allow for a process of appeal. If the above conditions can be met, there is a *prima facie* justification for the use of quarantine.¹⁴

Nancy Kass¹⁵ and James Childress,¹⁶ for example, have recently published frameworks for the ethical appraisal of public health programmes. In their frameworks, the effectiveness of an intervention plays an important role in justifying public health intervention. This is a double-edged sword, however. In health emergencies, it would be desirable to have knowledge that your actions, including that of quarantine, would be effective. But being constrained from action due to lack of evidence of effectiveness would severely hamper public health response—and quite possibly lead to the further transmission of disease. As public health officers face these difficult dilemmas, it is important that they err on the side

of public safety. It would be far better to defend oneself for unnecessary quarantine than to refrain from acting and expose individuals to a preventable disease, with subsequent morbidity and mortality. For quarantine, this infection should be spread from person to person. In diseases that are infectious but cannot be spread from person to person, such as anthrax, quarantine cannot be justified.

The COVID-19 pandemic rises to the level of a public health threat that could justify imposing restrictions on certain human rights, such as those that result from the imposition of quarantine or limiting freedom of movement. Although there is no guidance on isolation and quarantine measures which can be a model for all nations, the issue has been addressed by some U.S. state courts. Some conclusions those courts have reached are summarised here:

- Isolation or quarantine limiting freedom of movement should not be ordered if there is something else, such as directly observed therapy, that could protect the public health as effectively.¹⁷
- Isolation or quarantine should not be ordered if voluntary compliance can be obtained.¹⁸
- Isolation or quarantine should not be ordered unless the person poses an actual danger to others.¹⁹

Looking to U.S. case law regarding civil commitment, many scholars and some lower courts have concluded that isolation and quarantine are constitutional only when the government can show by clear and compelling evidence that they are the least restrictive means of protecting the public health. However, at least two federal courts reviewing post-detention challenges to Ebola quarantines held that the standard was not sufficiently well established to allow the claims to go forward. Persons who are detained, or whose liberty is otherwise restricted, are entitled people's basic needs, ensuring access to health care, medication, food, and sanitation to judicial review, traditionally under the writ of habeas corpus. Further, when governments detain people, they must meet those people's basic needs, ensuring access to health care, medication, food and sanitation. But many low-wage and gig workers cannot afford to stay at home. Nor can they handle the economic impact of other social distancing measures that may help to slow transmission.

The U.S. Courts have generally upheld the orders in deference of the states' broad powers to protect public health. Nevertheless, courts have occasionally intervened when a quarantine was unreasonable or when officials failed to follow necessary procedures. For example in *Jew Ho v. Williamson*,²⁰ a federal court struck down a quarantine imposed by San Francisco in response to an outbreak of bubonic plague because it was racially motivated and ill-suited to stop the outbreak. *Jew Ho*, a person of Chinese ancestry who lived within the quarantined district and operated a grocery store, alleged that the quarantine unlawfully prevented him "from selling his goods, wares, and merchandise."²¹ The complaint also alleged that while the quarantine was drawn in general terms and purported to impose the same restrictions, burdens, and limitations upon all persons within the quarantined district, in fact the restrictions were enforced only "against persons of the Chinese race and nationality."²² The Court concluded that the City's police powers were not without limitation, and the lack of any specific, relevant information about *Jew Ho* was a "difficulty or weakness that (was) inherent in the case."²³ The Court observed

that not “every statute enacted ostensibly for the promotion of (the public health) is to be accepted as a legitimate exertion of the police powers of the state.”²⁴ Rather, there are “limits beyond which legislation cannot rightfully go.”²⁵ Although statutes are entitled to the presumption of validity, “the courts must obey the constitution, rather than the law-making department of government,” and constitutional adherence requires that courts, “upon their own responsibility, determine whether, in any particular case, these limits have been passed.”²⁶

Balancing the police power of the state with our well-entrenched system of checks and balance, the court observed that the legislative branch cannot serve as the “exclusive judge as to what is a reasonable and just restraint upon the constitutional right of the citizen to pursue (his or her) business or profession.”²⁷ In other words, “the personal liberty of the citizen and his rights of property cannot be invaded under the disguise of a police regulation.”²⁸ The legislature thus may not, said the court “arbitrarily interfere with private business, or impose unusual and unnecessary restrictions upon lawful occupations.”²⁹ However, when reviewing a state’s use of its police power, the courts must exercise the “utmost caution” and countermand the legislature “only when it is clear that the ordinance or law so declared void passes entirely beyond the limits which bound the police power, and infringes upon rights secured by the fundamental law.”³⁰ The court invalidated the Chinatown quarantine as not reasonable to accomplish the purposes sought, and because the quarantine was applied discriminatorily, only against persons of Chinese ancestry within the quarantine district.

In March 2019, Rockland County, New York, prohibited all minors who were unvaccinated against measles from entering any place of public assembly. In *W. D. v. County of Rockland*,³¹ a New York State judge struck down that order, ruling that there was no emergency. Most states, however, do not require an emergency declaration in order to issue quarantine. Section 361 of the Public Health Service Act, 1944 grants the Surgeon General the power (which has now been delegated to the Centres for Disease Control and Prevention) to apprehend, detain, or issue a conditional release for the purpose of preventing the introduction into the country, or the spread across state lines, of a quarantinable disease, as designated by executive order. The current list includes “severe acute respiratory syndromes,” which encompasses Covid-19. The U.S. Supreme Court in *Addington v. Texas*³² has recognised that “civil commitment for any purpose constitutes a significant deprivation of liberty that requires due process protection.”

In *U.S. ex rel Siegel v. Shinnick*,³³ the Court has upheld the quarantine. In this case, a woman was quarantined for 14 days who had returned to U.S. from Stockholm deemed “a smallpox infected area” without presenting a certificate of vaccination,³⁴ even though she was asymptomatic and denied any direct exposure to the disease. The Court upheld the quarantine, stating:

(The) judgment required is that of a public health officer and not of a lawyer used to insist on positive evidence to support action; their task is to measure risk to the public and to seek for what can resume and, not finding it, to proceed reasonably to make the public health secure. They deal in a terrible context and the consequences of mistaken indulgence can be irretrievably tragic. To supersede their judgment there must be a reliable showing of error.

While there has been considerable scrutiny by Indian courts of issues of contested medical treatment, little judicial attention has addressed the exercise of public health powers. Indeed, the role of law in public health has been much neglected at both judicial and academic level. Historically, public health powers have been exercised over the most impoverished sectors of communities: the homeless, ethnic minority populations and the poor. In *Enhorn v. Sweden*,³⁵ the European Court of Human Rights (ECHR) recognised that 'the court has only to a very limited extent decided cases where a person has been detained for the prevention of spreading infectious diseases.' Most European states have statutory powers enabling a range of compulsory interventions, from compulsory vaccination to the compulsory medical examination, compulsory quarantine, and compulsory isolation or detention of infectious persons.

Incorporating human rights protections into quarantine and isolation laws

Worldwide over 100 countries implemented the policies of partial or complete lockdown measures to minimise the spread of the COVID-19 pandemic. Due to this unpredictable turn in events, the travel system has been paralyzed and about 3 billion people are stranded in their homes. No doubt, these quarantine steps are to minimise the transmission of this deadly contagious disease. However, we cannot neglect the adverse impact of self-isolation and quarantine on the public health, psychological distress and mental health issues including depression.

The COVID-19 pandemic rises to the level of public health threat that could justify imposing restrictions on certain human rights, such as those that result from the imposition of quarantine or limiting freedom of movement. Taking into careful consideration, special attention is required to protect every individual's human rights including non-discrimination, transparency and respect for human dignity in every country. Human rights are essential in shaping the pandemic response, and adopting extensive lockdown measures could breach the rights under international and regional human rights conventions. The whole idea is also supported by the Indian Constitution which lies upon the basic right of 'liberty' for everyone, and thus measures need to be taken to mitigate any consequences of violation of rights. On March 16, 2020 the United Nations Human Right Office, announced that states should not abuse emergency measures to suppress any human rights. The COVID-19 outbreak emergency measures should not be used as a basis, to target particular groups, minorities or any individuals. The constraints taken in response to COVID-19 pandemics must be motivated by legitimate public health objectives and, should not be used simply to suppress disagreements.³⁶

As stated earlier the Quarantine procedure has to be invoked only when it is absolutely necessary and the outbreak is inevitable because there is a high risk of people losing their employment if due care is not taken. It is important to note that Quarantining procedure is just a precautionary measure. It does not mean that all inmates are positive of infectious disease. Reports say that in 80-90% cases, it is a high possibility that they are negative. This makes it an utmost duty upon the government to make sure no violation of human rights transpires. In less-developed countries which suffer due to the lack of public infrastructure, it is apparent that they will be unable to safeguard the human rights of its citizens.

Quarantine laws and public health laws do give governments some fairly broad powers to declare quarantine and do restrict the movement of individuals. There is a very real sense in which these powers may well be needed in order to ensure an effective public health response to pandemic diseases. However, these laws are also clearly situated within a broader social context. Our perceptions of individual liberty and individual rights have undergone considerable change since most of our public health laws were originally introduced to control the disease anyway. Today, the public is likely to have expectations about the preservation of individual liberty and freedom of movement. These expectations underpin the political context for the development and application of public health laws in India and other countries.

As Gostin notes in his definition of public health laws, 'public health laws are not only about articulating the coercive powers of the state for enforcement of public health measures, but also about the limits of state power and the rights of individuals and communities. The language of human rights is increasingly part of the landscape for health law internationally.'³⁷ Given the potential for public health laws to impact upon the freedom of individuals, and the need for public health laws to balance the interests of individual and society, public health laws will ideally have a transparent ethical framework, articulating the principles upon which state intervention will be premised.³⁸ Although countries like USA, Canada, and some other countries in Europe have human rights charters or equivalents, which could provide procedural protections and safeguards in relation to quarantine and detention, India has yet to develop a Bill of rights at the central level. While India has amended the old 1897 legislation in terms of new threat posed by COVID-19, there is no comprehensive inclusion of human rights safeguards in the Infectious Diseases Act 1897 (as amended in 2020) which raises issues about the mechanisms for ensuring procedural safeguards in the event of pandemic.

The World Health Organisation (WHO) has acknowledged the importance of legal and ethical consideration to pandemic preparedness, noting that public health measures such as quarantine, compulsory vaccination, etc., public law need a legal framework to ensure transparent assessment and justification of the measures that are being considered, and to ensure coherence with international human rights law. Considering of ethical issues is also essential for, as the World Health Organisation has noted, ethical issues 'are part of the normative framework that is needed to assess the cultural acceptability of measures such as quarantine or selective vaccination of predefined risk groups.'³⁹ The exercise of state powers in terms of quarantine, isolation, and detention during a public health emergency is likely to be particularly controversial. The extent to which the state can and should exercise its powers in this area has become increasingly relevant in public health, as is clear from debates over detention of tuberculosis patients,⁴⁰ and from the use of quarantine during the SARS crisis.⁴¹

Public health laws may authorise the isolation of individuals and groups who may have been exposed to an infectious disease, as well as the closure of businesses and premises and the confiscation of property. The exercise of these powers must be based on public health considerations, without discrimination on grounds of race, gender, tribal background, or other inappropriate criteria. Public health laws should provide for the fair compensation of those who have suffered economic loss due to a public health order

affecting their property or facilities. The isolation and quarantine procedure has to be invoked only when it is an absolute necessity and the outbreak is inevitable because there is a high risk of people losing their employment.

Minimising the transmission of infectious diseases is a core function of public health law. Clearly defined legal powers are needed to respond to outbreaks of contagious and serious diseases at national level. The appropriate exercise of legal powers will vary according to the seriousness of the disease, the means of transmission, and how easily the disease is transmitted. Some diseases are entirely preventable by vaccination (e.g. Measles and Polio), or by access to improved sanitation and clean drinking water (e.g. diarrhoeal and parasitic diseases). Others are treatable when detected in a timely manner (e.g. tuberculosis and malaria). The epidemic of HIV can be substantially reduced through laws supporting access to treatment, combined with measures to educate and support individuals and communities to implement proven strategies for preventing transmission. Parties to International Health Regulation (2005) have an obligation to assess and notify WHO of all events occurring within their territories that may constitute a public health emergency of international concern.⁴²

Isolating persons, who have or may have been exposed to a serious contagious disease, in order to prevent transmission, is a long-established public health strategy that may be applied to both individuals and groups, as effective tools for the prevention and control of infectious disease. Where an outbreak of a serious, contagious disease occurs, it will often be impractical or impossible to accurately identify cases and carriers of disease. For this reason, public health laws of many countries have authorised officials to evacuate or to order the closure of premises (e.g. markets, schools, gyms and movie theatres) and to prevent access to public spaces where people would otherwise gather. Since the closure of premises can affect businesses and livelihoods, it is important for the operation of public health orders to be reviewed regularly and to be based on public health considerations, without discrimination on grounds of race, gender, tribal background or other inappropriate criteria.

Public health orders for the evacuation or closure of premises, or to remove noxious articles (including objects, birds, and animals) that are contaminated with an infectious agent. Where the confiscation or destruction of private property causes more than trivial economic loss, public health laws should require reasonable compensation to be paid to the owner. This principle can have an important benefit for public health: laws that provide for just compensation are more likely to secure the trust and voluntary cooperation of those who are poor and economically vulnerable, and who for that reason are most likely to be adversely affected by a public health order.

Strengthening ethical principles into infectious disease legislation

Screening individuals to determine if they have been infected with or exposed to an infectious disease is a core public health strategy. Screening enables health care providers to begin treatment in a timely manner, to manage co-morbidities more effectively, to encourage patients to reduce high-risk behaviour and, in certain cases, to identify the need for compulsory treatment. In addition to reducing the severity of illness, early treatment may also reduce transmission rates. For example, early treatment with

antiretroviral drugs lowers the viral load of people with HIV and significantly reduces the risk of transmission. The WHO supports the expansion of testing and counselling in order to identify the disease early on in their infection and to “link them successfully to prevention, care, and treatment services?”⁴³

In addition to authorising screening, including mandatory screening in appropriate circumstances, public health laws can improve the success of screening programmes by including counselling requirements, by ensuring the confidentiality of test results, and by protecting individuals diagnosed with particular diseases from discrimination. Laws drafted in accordance with human rights principles increase the likelihood that individuals will voluntarily seek out testing and treatment services.⁴⁴

Public health laws can support the control of infectious diseases in two important ways. Firstly, law has a proactive or preventive role: improving access to vaccinations and effective medicines, together with the screening, education, counselling and other strategies that aim to minimise exposure to disease. Secondly, law has a reactive role: supporting access to treatment, and authorising health departments and healthcare providers to limit contact with infectious individuals and to exercise emergency powers in response to disease outbreaks. Because infectious disease control and prevention laws may involve interference with freedom of movement, the right to control one’s health and body, and with privacy and property rights, public health laws should embody a decision making process that balances these personal rights with the public’s health in an ethical and transparent way. The public health laws should adopt the following ethical principles:

- a. Public health laws must identify a set of ethical principles that are relevant and sets out what they mean in terms of the exercise of coercive power over individuals, within a legal framework for control of infectious diseases.⁴⁵
- b. The coercive powers should be exercised on the basis of a demonstrable threat to public health. Mandatory physical examination, treatment or isolation should require a reasonable suspicion that the person is contagious or could pose harm to others.
- c. The specific measures adopted by governments must be appropriate to prevent or reduce the threat. Government should monitor the effectiveness of public health interventions and ensure that they are based on sound science.
- d. Governments must strive to ensure that there is a reasonable fit between the coercive measures imposed on individuals, and the public health benefits that they seek to achieve.
- e. Governments should adopt the least burdensome measure from among the measures that are available and reasonably appropriate to mitigate the risks in question. Restrictions that are “gratuitously onerous or unfair” may “overstep ethical boundaries.”⁴⁶
- f. The risks, benefits and burdens of public health interventions should be shared fairly. For example, vulnerable populations should not be targeted with restrictive measures, nor excluded or given lower priority in the allocation of treatment, vaccines or other benefits.
- g. The public should have an opportunity to participate in the formulation of public health policies, and governments should give reasons for policies and decisions that restrict individual freedoms. Openness and accountability are essential to

generating public trust, and are likely to improve public health decision-making. Without public trust and voluntary cooperation, governments will find it harder to achieve their goals and to act in the public interest.

Poverty, homelessness, marginalisation, and pandemics

Epidemics and pandemics have a disproportionate impact on people experiencing poverty, marginalization, stigmatization and discrimination. Amidst the current Coronavirus disease 2019 (Covid-19) pandemic, this disparity is particularly relevant for individuals who experience homelessness. Homeless shelters have also been an ideal environment for transmission of severe acute respiratory syndrome coronavirus-2 (SARS-CoV-2) because of shared living spaces, crowding, difficulty achieving physical distancing and high population turnover.⁴⁷ People who are homeless also have a high prevalence of chronic health conditions that increase the risk of poor outcomes if they develop COVID-19.⁴⁸ Additional challenges include limited access to health or social services.⁴⁹ Screening and treatment services such as primary care clinics may have been less accessible for individuals experiencing homelessness. The transient nature of homeless populations adds further complexities with respect to contact tracing to contain the spread of SARS-CoV-2 and reduce community transmission.⁵⁰ Additionally, the limited availability of services relative to the needs of the population poses major constraints on control efforts, as inadequate resources (e.g., space and personal protective equipment) make enforcing public health protocols extremely difficult at many shelters.⁵¹

COVID-19 and associated public health control measures pose particular challenges and increased risks of harm for people experiencing homelessness. Measures have been implemented across the national boundaries to increase capacity to allow safe physical distancing for homeless people, including arranging temporary housing, enlarging shelter spaces and creating isolation sites for homeless people with COVID-19. However, the diverse needs of various subgroups of people experiencing homelessness must be considered to ensure implementation of effective and equity-focused interventions. The COVID-19 pandemic has highlighted the importance of housing as a social determinant of health and raises the question of whether current approaches to addressing homelessness should be re-evaluated.

The risk of severe COVID-19 is increased for people experiencing homelessness owing to the high prevalence of medical comorbidities including heart disease, respiratory conditions, liver disease and high rates of smoking in homeless populations.⁵² An increasing proportion of people experiencing homelessness are older than 65 years, a factor that also exacerbates the risk of developing severe COVID-19.⁵³ Individuals who experience homelessness are also likely to face criminalization of their daily life. For example, it is difficult, if not impossible, for homeless individuals to avoid infractions of physical distancing orders when they line up to enter a shelter or meal program or when they sit on a park bench. Homeless people in both Canada and the US have reportedly received fines ranging from \$500 to \$10 000 for such violations, which is highly problematic.⁵⁴ The same situation occurred in India when the poor and homeless people have been fined from Rs. 500 to 1000 by the police for violation of safety regulations. As described above, interventions that are designed to house, isolate and treat people experiencing homelessness can begin to address the challenges, yet gaps remain.

Programs and policies for addressing COVID-19 should be developed with and by indigenous organizations to ensure that stigmatization, racism and ongoing colonialization experienced by the poor people and tribes is not compounded by public health approaches to the pandemic and that the unique needs of indigenous people experiencing homelessness are met. The risk factors can be summarised here as:

- Individuals experiencing homelessness are at increased risk of infection with severe acute respiratory syndrome coronavirus 2 owing to their lack of safe housing and are also at higher risk of severe coronavirus disease 2019 (COVID-19), given the high prevalence of risk factors in homeless populations.
- People experiencing homelessness often find it difficult to adhere to public health directives such as physical distancing, isolation and quarantine because of shelter conditions and other challenges.
- Several cities and regions have taken measures to provide spaces for people experiencing homelessness, to ensure physical distancing, isolation or quarantine; however, service providers must focus on building relationships and rapport, and take a trauma-informed approach to care, to persuade individuals to follow advice.
- Closure of regular services may put people experiencing homelessness at risk of other harms, such as those related to unsafe substance use and intimate partner violence.
- The COVID-19 pandemic has highlighted the importance of housing as a social determinant of health and raises the question of whether current approaches to addressing homelessness should be re-evaluated.

Criminalisation of transmission: Lessons from HIV policies

The appropriate role of criminal law in national efforts to prevent transmission of COVID-19 or other transmissible infections is often controversial. Public health laws often contain penalties for failing to comply with public health orders made by authorities, or for engaging in behaviours that place public health at risk. However, policy-makers should not ignore the potential for unintended consequences arising from laws that create criminal offences for recklessly exposing another person to COVID-19, or for failing to disclose one's Corona-positive status to close partner or relatives. The UN policy on HIV/AIDS clearly indicates that governments should carefully consider the appropriate role of criminal law when making or amending laws to prevent the transmission of infectious and communicable diseases. For example, criminal penalties for transmission of infectious diseases may create disincentives to individuals to come forward for testing and treatment, or may provide the pretext for harassment and violence against vulnerable groups.⁵⁵ Encouraging personal responsibility and self-protection is critical, especially in countries where rates of infectious diseases are high.

In the past, HIV and other contagious cases have been criminalised by the national governments throughout the world. Laws like these may be intended to encourage personal responsibility in the hope that individuals will modify their behaviour in order to avoid criminal penalties. They may also be motivated by the belief that those who fail to protect others from transmission, or from the risk of transmission, deserve punishment. On the other hand, the broader impact of these laws on transmission rates and public health can be negative. The final report of the Global Commission on HIV and the Law pointed out that criminal laws against HIV in many countries are overly broad, carry

draconian penalties, and are “virtually impossible to enforce with any semblance of fairness.”⁵⁶ For example, sex workers and women in abusive relationships may face violence if required to disclose their HIV status to sexual partners.⁵⁷ To the extent that criminal penalties have any effect on sexual behaviour at all,⁵⁸ they may create disincentives to individuals to come forward for HIV testing and treatment, for fear of criminal penalties or official investigation. This is counter-productive, since it is important to encourage individuals to monitor their HIV status and to seek treatment as soon as they are diagnosed, both because those who acquired the virus recently will have a higher viral load and will be more likely to transmit it,⁵⁹ and because effective treatment with antiretroviral therapy lowers viral load and makes it less likely that HIV positive individuals will pass on the virus to others.

An additional concern that relates to mandatory disclosure laws is the potential for such laws to subtly undermine disease control efforts by weakening the assumption that individuals are primarily responsible for protecting themselves from the risks of transmission of HIV and other sexually transmissible diseases. In countries where large numbers of the population are infected, relying on voluntary disclosure by sexual partners is unrealistic. Individuals may not know their status, or may be ashamed, fearful, or otherwise unwilling to reveal information about themselves. In these circumstances, personal responsibility and self-protection remain critical.

Global Commission on HIV and the Law, have recommended that countries should only prosecute HIV transmission in cases of intentional and actual transmission, and require a high standard of evidence and proof. The Global Commission recommended that countries repeal provisions that explicitly criminalise HIV transmission, and rely on existing laws against assault, laws against causing bodily harm, or laws that permit public health officials to intervene when a person’s behaviour creates a serious risk of transmission of communicable disease.⁶⁰

In circumstances where a disease or infection is transmitted by sexual contact or other forms of human behaviour that are private and difficult to monitor, the priority for governments is to create an enabling legal environment that supports those behaviours that are most successful in preventing further transmission. This is the challenge of HIV and the law. We can take a lesson from the HIV/AIDS. High rates of infection with HIV, particularly in Sub-Saharan Africa, combined with inadequate access to treatment, have resulted in a heavy burden of disease from AIDS, dramatically reducing average life expectancy, productivity, and creating major obstacles to the progressive realisation of the right to health.⁶¹

Informed consent and compulsory treatment orders

Consent is a precondition and a requirement for lawful medical treatment. Anyone who intentionally or recklessly touches another without that person’s consent will generally commit both a tort and a crime. Health professionals administering medical treatment to a patient with capacity therefore need to obtain a valid consent. Failing to do so can give rise to an action for criminal force or negligence and can constitute the crime.⁶² Right to give or not to give consent for medical treatment has been recognised as a part of human rights both under national and international law.

Although the right to consent to medical treatment is a fundamental individual human right, there are circumstances in which public health authorities may be justified in ordering the compulsory diagnosis and treatment of individuals. Public health laws should authorise compulsory treatment orders only in circumstances where the person in question is unable or unwilling to consent to a diagnostic procedure or treatment, and where their behaviour creates a significant risk of transmission of a serious disease.⁶³ For example, South Africa's National Health Act states that a health service may not be provided to a user without the user's informed consent, unless "failure to treat the user, or group of people which includes the user, will result in a serious risk to public health."⁶⁴

A treatment order should clearly state the grounds on which it has been made, should set out any restrictions or limitations on behaviour, and should take into account the principle that individual liberty should only be restricted to the extent necessary to most effectively reduce risks to public health. Public health laws should also include procedural rights to protect the interests of individuals, subject to treatment orders. This may include the requirement for a court to review each compulsory treatment order within a defined period of time. Public health officials must ensure that laws authorising treatment without consent are never used to discriminate against or to marginalize vulnerable individuals and groups.⁶⁵

It is also worth briefly mentioning that all the major moral theories could accept some limitations on refusals. Even individual rights-based theories will not allow patients to refuse interventions that are necessary to protect the more important rights of others. An extreme example would be where overriding a competent patient's refusal of treatment is the only way of preventing the spread of a highly infectious, fatal disease.⁶⁶ The intervention can be justified only by reference to compelling counter-concerns recognised by the tenets of public health in question.

Using international law as a global strategy to control infectious disease

International human rights law in controlling infectious diseases can be more effective and positive. The International Health Regulation administered by the World Health Organization (WHO) represent the most important set of international legal rules relating to infectious disease control, but the regulations only apply to certain diseases. The revised International Health Regulations 2005 (IHR), adopted by the World Health Assembly in 2005, are binding on all WHO Member States and provide a regulatory framework for international control of public health emergencies. The purpose of the IHR is to prevent and manage the public health risks arising from the international spread of infectious diseases, while avoiding "unnecessary interference with international traffic and trade."⁶⁷ Some features of IHR include:

- The legal obligation imposed on each country to notify WHO of events that may constitute a public health emergency of international concern within its territory.⁶⁸
- The obligation of countries to "develop, strengthen and maintain" their national capacities to detect, assess, report and respond effectively to public health risks and emergencies,⁶⁹ and

- The ability of the WHO Director-General to make non-binding, temporary recommendations to countries in whose territory a public health emergency of international concern has arisen.⁷⁰

Article 6 of the International Health Regulations (2005) (IHR) imposes an obligation on countries to notify WHO, via the National IHR Focal Point, of “all events which may constitute a public health emergency of international concern within its territory.”⁷¹ The IHR defines a “public health emergency of international concern” as an extraordinary event that is determined to “constitute a public health risk to other States through the international spread of disease and to potentially require a coordinated international response.”⁷²

The global nature of the threat posed by new and re-emerging infectious diseases will require international cooperation in identifying, controlling, and preventing these diseases. Because of this need for international cooperation, international law will certainly play a role in the global strategy for the control of emerging diseases. The emerging infections are a global problem that requires a global strategy. The traditional distinctions between national and international political, social and economic activities are losing their importance.⁷³ In public health, while states have historically cooperated on infectious disease control, first through international sanitary treaties and later through the World Health Organisation (WHO). While international cooperation is not new, current global circumstances confronting the control of infectious disease are quite possibly lead to the further transmission of disease. Globalisation is also at work in public health.

The assertion that country cannot tackle emerging infectious diseases by itself demonstrates that public health policy has been denationalised. The de-nationalisation can create another problem in the infection of diseases. In the European Union, for example, the free movement of goods, capital and labour makes it more difficult for member states to protect domestic populations from diseases acquired in other countries.⁷⁴ The importance of health is mentioned in international declarations⁷⁵ and treaties⁷⁶ leading some legal scholars to argue that international law creates a “right to health,”⁷⁷ but this “right” does not directly address the control of infectious diseases. The WHO has refrained from adopting rules on trade in human blood and organs, which does raise issues of infectious disease control as illustrated by the sale of HIV-contaminated blood in international commerce.⁷⁸ Issues of disease control also appear in specialised treaty regimes outside the WHO, such as treaties controlling marine pollution from ships.⁷⁹ Other areas of international public health law, for example, rules about infant formula and guidelines on pharmaceutical safety, do not deal with the control of infectious diseases.⁸⁰

The effectiveness of existing international law on infectious disease control has been called a failure in compliance with the International Health Regulations. Many States have adopted exclusionary policies that, according to experts, violated provisions of the health regulations. The World Health Organization acknowledges the need for international legal agreement in dealing with emerging infections. The global threat posed by COVID-19 represents in many ways a test case for international public health law. The effectiveness of international law again depends on the consent of the States, which means that sovereignty and its exercise determine the fate of international legal rules.⁸¹ In adopting a

legal strategy for its emerging infectious disease action plan, the World Health Organization has to convince its member states to take certain actions in response to disease emergence. The sovereignty of States looms large in formulating a global response to emerging infections, despite the fact that the process of globalization undermines the sovereignty of the States to deal nationally with these infectious diseases.⁸² In other words, the problem bypasses the state, but the solution has to rely on the state through the medium of international law.⁸³

As public health officers face these difficult dilemmas, it is important that they err on the side of public safety. It would be far better to defend oneself for unnecessary quarantine than to refrain from acting and expose individuals to a preventable disease, with subsequent morbidity and mortality. In diseases that are infectious but cannot be spread from person to person, such as anthrax, quarantine cannot be justified. The very nature of the emerging disease threat poses special difficulties for international law.⁸⁴ The global scope of the problem necessitates agreement by most states to control emerging diseases. If any major country or group of countries does not participate, a gap in the global surveillance and control network threatens the efficacy of the entire effort.

International human rights law, notably the International Covenant on Civil and Political Rights (ICCPR), which India has signed and ratified, requires that restrictions on human rights in the name of public health or a public emergency meet requirements of legality, evidence-based necessity, and proportionality.⁸⁵ Restrictions such as quarantine or isolation of symptomatic people must, at a minimum, be provided for and carried out in accordance with the law. They must be strictly necessary to achieve a legitimate objective, the least intrusive and restrictive available to reach the objective, based on scientific evidence, neither arbitrary nor discriminatory in application, of limited duration, respectful of human dignity, and subject to review. When quarantines are imposed, governments have absolute obligations to ensure access to food, water, and health care.⁸⁶

Conclusion

Coronavirus (COVID-19) has presented a new challenge insofar as it is highly contagious, deadly in a percentage of cases, and difficult to manage because of its pandemic nature. It has created dire public health emergency, while simultaneously halting a substantial portion of the nation's economy. Business failures and job losses have become serious problems in their own right. Given the rapidity of medical progress and the effective public health interventions available to prevent and treat communicable diseases, such as HIV infection and small pox, it may be right to say that state policy makers should refrain from enacting laws that criminalize infectious disease transmission. In this context, it is necessary to modernize existing criminalization laws and to direct resources to evidenced-based prevention interventions that, when available and accessible, can significantly reduce the impact of infectious diseases in India and globally.

The public health laws must respect the rights and wellbeing of detainees. In practice, use of the restrictions must follow two imperatives: First, exercise of the powers must be based on the best scientific evidence available. This requires close collaboration with national and international public health experts to fully understand factors such as the incubation period of the virus, the known risks of transmissions and how to successfully

manage treatment of the virus itself. Second, the rights and wellbeing of those detained must be respected. This includes maintaining clear lines of communication, listening to those people's concerns and always favouring the least restrictive measures required to control the risk of transmission. It also means recognising that those detained are inherently vulnerable, not only in a medical sense but also to the social and emotional repercussions of being identified as a (possible) public health risk.

There have been many calls from different sides for reform of public health legislation in India by academic commentators. Public health law has undergone a process of reform in other countries that had adopted their public health laws from English law; following the SARS scare in 2003 any doubt as to the implications of the human rights for the public health law must now have been settled by the governmental legislation and judicial decisions. We can only call upon the government to make reform of public health an issue of the highest priority, and not to wait for the threat of a new or re-emerging disease in order to pass with haste emergency legislation.

The exercise of state powers in terms of quarantine, isolation and detention during a public health emergency is likely to be particularly controversial in Western liberal democracies such as Australia and United States. The extent to which the state can and should exercise its powers in this area has become increasingly relevant in public health. Law has the potential to be a very useful tool for the attainment of public health. Bad law, however, can serve to create obstacles to public health. Public health consultants should be more cautious in using detention powers, even in cases of serious risk of disease spread by a non-compliant patient, because of lack of clarity of the status of these powers in relation to human rights. The impact of lockdowns on jobs, livelihoods, access to services, including health care, food, water, education and social services, safety at home, adequate standards of living and family life can be severe, the public health laws must reflect the features of human rights in its structure. While opinions of public health authorities must be respected, their decisions must be based upon the latest knowledge of epidemiology, virology, bacteriology, and public health.

FootNote

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¹ (T)he Epidemic Diseases Act, 1897 was introduced by the colonial government to tackle the epidemic bubonic plague that had spread in the erstwhile Bombay Presidency in the 1890s. Since then the act is routinely enforced across the country for dealing with swine flu, cholera, dengue malaria, small pox, etc.

² The Epidemic Diseases (Amendment) Ordinance, 2020 was promulgated on April 22, 2020. The Ordinance amends the Epidemic Diseases Act, 1897. The Ordinance amends the act to include protections for healthcare personnel combating epidemic diseases and expands the powers of the central government to prevent the spread of such diseases.

³ *The Queen Impress v. Krishnappa*, (1883) ILR 7 Mad 276.

⁴ *Nidar Mal*, (1902) PR No. 22 9Cr) 56.

⁵ See sections 271, 272, and 273 of the *Bharatiya Nyaya Sanhita*, 2023.

⁶ See *People v. Aleynikov*, 31 NY 3d 383, 397 (2018).

⁷ See, <https://www.merriam-webster.com/dictionary/epidemic>

⁸ *Ibid*.

- ⁹ Ross Upshur, Principles for the Justification of Public Health Intervention, *Canadian Journal of Public Health*, (2002) 93 (2) 101-103.
- ¹⁰ *Ibid.*
- ¹¹ Nancy E. Kass, An Ethics Framework for Public Health, *American Journal of Public Health*, (2001) 91 (11) 1776-1782.
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- ¹³ Ross Upshur, Principles for the Justification of Public Health Intervention, *supra* note 9.
- ¹⁴ *Ibid.*
- ¹⁵ Nancy Kass, An Ethics Framework for Public Health, *supra* note 11.
- ¹⁶ James F. Childress, Ruth R. Faden et al., Public Health Ethics: Mapping the Terrain, *Journal of Law, Medicine and Ethics*, (2001) 30 (2) 170-178.
- ¹⁷ See, e.g., *City of Newark v. J.S.*, 652 A. 2d 265 (N.J. 1993).
- ¹⁸ See, e.g., *City of New York City v. Doe*, 614 N.Y.S.2d 8 (App. Div. 1994). (Confinement in hospital for treatment of tuberculosis upheld when the evidence showed that the patient had a history of refusing to cooperate with voluntary directly observed therapy).
- ¹⁹ See, *City of Newark v. J.S.*, 652 A.2d 265 (N.J. 1993). (This is consistent with G.S. 130A-145(a), which states that isolation or quarantine authority can only be exercised when and so long as the public health is endangered).
- ²⁰ 103 F. 10 (N.D. Cal. 1900).
- ²¹ *Id.* at 12.
- ²² *Id.* at 13.
- ²³ *Id.* at 15.
- ²⁴ *Id.* at 17.
- ²⁵ *Ibid.*
- ²⁶ *Ibid.*
- ²⁷ *Id.* at 19.
- ²⁸ *Ibid.*
- ²⁹ *Id.* at 20.
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- ³¹ (2019) NY Slip Op 29111.
- ³² 441 U.S. 418, 425 (1979).
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- ³⁴ *Id.* at 790-91.
- ³⁵ (2005) E.C.H.R. 56529/00.
- ³⁶ United Nations Human Rights: Office of the Commissioners. Available at [rights.https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=25722](https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=25722).
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